



LOS ANGELES COUNTY COMMISSION ON HIV

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www.hivcommission-la.info

COMMISSION ON HIV ANNUAL MEETING MINUTES November 14, 2013

Approved
2/13/2014

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT (cont.)	COMMISSION MEMBERS PRESENT (cont.)	DHSP STAFF
Michael Johnson, Esq., <i>Co-Chair</i> / Kevin James Donnelly	David Kelly, MBA, JD/Alex Castillo AJ King, MPH	Jason Tran/Rob Lester, MPP Monique Tula	John Mesta Carlos Vega-Matos, MPA
Alvaro Ballesteros, MBA	Mitchell Kushner, MPH, MD	Terrell Winder	
Joseph Cadden, MD	Bradley Land	Fariba Younai, DDS	
Raquel Cataldo	Patsy Lawson	Richard Zaldivar	COMMISSION STAFF/CONSULTANTS
Pat Crosby (<i>pending</i>)	Ted Liso/Douglas Lantis, MBA		
Dahlia Ferlito, MPH (<i>pending</i>)	Abad Lopez		Dawn McClendon
Suzette Flynn	Marc McMillin	COMMISSION MEMBERS ABSENT	Jane Nachazel
Aaron Fox, MPM	Jose Munoz		Glenda Pinney, MPH, JD
Lynnea Garbutt	Victoria Ortega	Ricky Rosales, <i>Co-Chair</i>	James Stewart
Gambit Geniess	Mario Pérez, MPH	Michelle Enfield	Craig Vincent-Jones, MHA
David Giugni, LCSW	Gregory Rios	Lilia Espinoza, PhD	Nicole Werner
Terry Goddard, MA	Juan Rivera	Sharon Holloway/Ismael Morales	
Grissel Granados, MSW	Jill Rotenberg	Ayanna Kiburi, MPH	
Joseph Green/Erik Sanjurjo, MA	Sabel Samone-Loreca/Susan Forrest	Lee Kochems, MA/James Chud, MS	
Anthony Gutierrez, MA	Shoshanna Scholar	Angélica Palmeros, MSW	
Kimler Gutierrez (<i>pending</i>)	LaShonda Spencer, MD	Harold Sterker, MPH	
PUBLIC			
Margarita Barragan	Tina Henderson	Richard Ray	Hylie Sims
Heidi Booth	Miki Jackson	Laura Ramos	Anastasia Tarpeh
Tangerine Brigham	Luke Klipp	Lise Ransdell	Jason Wise
Maria Calleros	Joseph Leahy	Tania Rodriguez	Jody Yoxsimer
Martin Celaya	Karen Mark, MD	Martha Ron	
Alicia Eccles	Steve Mercieca	Gayle Rutherford	
Marc Hauptert	Jessica Perez	John Schunhoff, PhD	

1. **REGISTRATION:** Registration opened at 8:30 am.

2. **CALL TO ORDER:**

- A. **Welcome and Introductions:** Mr. Johnson opened the meeting at 9:30 am. He welcomed Commissioners and stakeholders to the discussion of changes coming to the delivery system and the Commission's response as a planning body.

Commission on HIV Meeting Minutes

November 14, 2013

Page 2 of 10

B. Roll Call (Present): Ballesteros, Cadden, Cataldo, Crosby, Ferlito, Flynn, Fox, Garbutt, Geniess, Giugni, Goddard, Granados, Green, Anthony Gutierrez, Kimler Gutierrez, Johnson/Donnelly, Kelly, Kushner, Land, Lawson, Liso/Lantis, Lopez, McMillin, Munoz, Ortega, Pérez, Rios, Rivera, Rotenberg, Samone-Loreca/Forrest, Scholar, Spencer, Tran/Lester, Tula, Winder, Younai, Zaldivar

3. APPROVAL OF AGENDA:

MOTION 1: Approve the Agenda Order (*Passed by Consensus*).

4. PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP:

- Mr. Hauptert, Executive Director, West Hollywood Library Foundation announced two Dr. Michael Gottlieb HIV/AIDS Information Center events. The "Dallas Buyers Club" will be shown World AIDS Day, 12/1/2013, at the Pacific Design Center with the film's producer; Dr. David Hardy, medical director; and possibly stars of the film. Agency discounts such as for students or clients can be arranged by emailing Mr. Hauptert at marc@whlf.org.
- The Foundation is also producing "20/20: An Intergenerational Panel" to look back 20 years at the beginnings of the epidemic and forward 20 years toward tomorrow's vision. The event will be 12/11/2013 in the West Hollywood City Council Chambers. For more information go to www.2020forum.net.

5. COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP:

- Mr. Johnson received a call from County Counsel asking him to clarify if the Commission prohibits Commissioners from discussing issues that have transpired between the County and AIDS Healthcare Foundation (AHF), as some Commission members have suggested. Mr. Johnson responded that Commissioners are not prohibited from discussing AHF or other providers. In order to fulfill many of its duties, the Commission must discuss provider and service delivery issues.
- It is best to keep speculation to a minimum during pending litigation because discovery is ongoing and the parties are making their cases. The Commission has a right and duty to discuss how to address outcomes once litigation is complete.
- There will inevitably be speculation as health care reform rolls out, consumers migrate to new systems of care, providers adapt to new payment systems and constraints, and the Commission must advise the County and other departments on how best to ensure service delivery. Nevertheless, the Commission must make decisions on the available facts and data.

6. KEYNOTE ADDRESS: The Commission on HIV: From Its Origins as a RW Planning Council to Charting a New Community Health Planning Role in Expanded Health Care Systems:

- Mr. Johnson introduced Dr. Schunhoff, retired, who is the former Acting Director, Department of Health Services (DHS); former Chief Deputy, Department of Public Health (DPH); and former Director, Office of AIDS Programs and Policy, the predecessor to the Division of HIV and STD Programs (DHSP). Mr. Johnson praised his compassion and mentorship.
- Dr. Schunhoff noted the first County AIDS activity was establishing an AIDS Program Office in 1985, staffed by a medical director, an administrator, an administrative assistant II, a senior health educator and five health educators. This reflected the traditional approach of sending County staff into communities, rather than community agencies leading education.
- The first planning body to address AIDS in the County was a task force launched in the mid-1980's, just a few years after AIDS was first identified, by City of Los Angeles Mayor Tom Bradley and County Supervisor Edmund Edelman.
- In 1987, the Board voted to fund an active response. DHS hired Dr. Schunhoff that February as an in-house consultant to write the first budget to address AIDS service needs in the County. The budget process begins in Fall for the next July so was already underway. Dr. Schunhoff lacked sufficient time to convene community groups, but spent a month talking with as many stakeholders as possible. His proposed budget was \$22 million. \$3 to \$4 million was funded the first year with more added in subsequent years.
- AIDS planning also began in 1987 with creation of the AIDS Commission. Commissions are usually formed by supervisorial appointees with occasional outside body nominees, but not broad community participation. The first AIDS Commission included two appointees per supervisor with representatives from the American Red Cross, the Los Angeles County Medical Association, the Hospital Commission, the Los Angeles Gay and Lesbian Center, AIDS Project Los Angeles, and a few others.
- The AIDS Commission focused its first year on two initiatives: the LAC+USC AIDS ward, a politically and powerfully significant issue at the time; and patient care alternatives such as home health care, hospice and day care funding. It also began to empower community agencies by contracting them to provide education for a more effective response.
- Even then, federal HIV/AIDS funding for the County came via two Health and Human Services agencies: Centers for Disease Control and Prevention (CDC); and Health Resources and Services Administration (HRSA) for care starting with the AIDS

demonstration projects, which preceded the Ryan White CARE Act. CDC HIV/AIDS activities have never been funded due to specific legislative authority; instead, the CDC develops programs based on its general authority.

- In the early 1990s, most community agencies attempted to coordinate community planning and organization by founding the AIDS Regional Board. It formed task forces on—e.g., HIV care, substance abuse, and case management—to coordinate care rather than compete for limited resources. Unfortunately, that type of planning is hard to implement countywide with funding source bidding requirements.
- The Commission and Board were merged when the first Ryan White planning body was formed. The merger did not roll out smoothly and HRSA also began to become more restrictive about membership. The model was eventually revised, but revisions were difficult because the County is unaccustomed to leaving planning to solely the community.
- The CDC lagged HRSA by several years before requiring community planning by states and locales that received direct funding. The County used a structural device to craft the new body as a kind of special committee of the Commission. That permitted the bodies to be tied together while allowing more flexibility, since members did not need to be Board-appointed. Developments over time have increasingly supported interaction between the two bodies, e.g., early intervention/treatment is now recognized as prevention.
- The Affordable Care Act (ACA) will have a major impact on how the Commission functions in the future. Many PLWH will migrate to Medicaid expansion or into the insurance exchanges. That will require the Commission to work with health plans to ensure adequate PLWH care. Concurrently, it is hoped the Ryan White Program will continue to fund services for the undocumented and some other PLWH populations not covered by the ACA. The Commission must work to maintain those services, as well as the many Ryan White services designed to tie into medical services that ACA does not address.
- Prevention still needs a strong voice and, 30 years into the epidemic, considerable work remains.
- Mr. Fox appreciated the history and asked how well we have responded as a jurisdiction. Dr. Schunhoff felt the County did a decent job in the 1980s-1990s by developing a comprehensive service program, despite some gaps, with County facilities and community agencies. He felt prevention overall was about a “B,” though he acknowledged it is hard to impact behavior. He was uncertain whether lower IDU prevalence than in eastern areas was due to County efforts or luck.
- Mr. Land asked for advice on engaging other health plans. Participation has been poor for previous efforts. Dr. Schunhoff suggested starting with the Medi-Cal plans: LA Care and HealthNet. Ask for presentations on how they assure PLWH in their plans get the care and services they need, including mental health services.
- Mr. Land also asked how to integrate HIV-related services into other systems, much like ADAP is integrated in a simple and accessible way. Dr. Schunhoff recommended determining how current Ryan White-funded services are related to PLWH in the various systems, the role of HIV providers contracted by the plans, and how more services can be coordinated.
- Two years ago, DHS spent significant time negotiating an agreement between the County and LA Care which essentially caused LA Care to take on the role of the DHS health plan, which phased out DHS running a community health plan. Discussions involved many pieces, e.g., the formulary, mental health, and how to fund services. That can be a coordination model.
- Mr. McMillin expressed concern about maintaining standards and encouraging use of best practices as PLWH move to Covered California. Dr. Schunhoff said the County has little enforcement power with plans, but can work to persuade plans to adopt standards and best practices, as well as educate PLWH about them. Services funded by Ryan White can be required to follow them.
- Mr. Johnson asked what advice he would give plans. Dr. Schunhoff hoped they had already educated themselves about unique PLWH needs, as well as precedents already set in the HIV system of care. LA Care has done that groundwork.
- Mr. Land asked why the County was asked to administer Ryan White funds when it usually goes to the largest city in an Eligible Metropolitan Area. Dr. Schunhoff said legislation really pertains to what entity includes the health department. The only County cities with health departments are Long Beach, Pasadena and, to an extent, Vernon. There was already a precedent to bypass states in lieu of local levels when the CDC initiated general prevention funding. Six cities and their states were directly funded: Chicago, Houston, Los Angeles, Miami, New York and San Francisco.

7. EMERGING TRENDS: How the Commission Can Preserve and Protect Continuity of HIV Care and Services in a New Managed Health Care Environment:

- Ms. Brigham, Deputy Director, Managed Care, DHS, invited Ms. Calleros, Director, Safety Net Initiatives, LA Care, to help address migration of Ryan White patients into other systems. HealthNet was invited, but could not send a representative at short notice. She will work with Mr. Vincent-Jones to schedule her, Ms. Calleros and a HealthNet representative at a later meeting.

Commission on HIV Meeting Minutes

November 14, 2013

Page 4 of 10

- Ms. Calleros worked on Low Income Health Program (LIHP) and Medi-Cal expansion preparations. LA Care started preparing with the County for the upcoming transition into Medi-Cal in January. By 1/1/2014, 275,000 people are expected to fold into Medi-Cal.
- LA Care recognizes there is a subset of the LIHP population that previously received services through Ryan White-funded clinics, moved into Healthy Way LA (HWLA), and who will now migrate into Medi-Cal. That population has complex service and chronic health care needs. As such, it is important to identify and address wraparound services, e.g., what does Ryan White provide, what was provided under HWLA, and what Ryan White wrap-around services do not crossover into Medi-Cal?
- DPH helped the managed care plans understand Ryan White benefits, such as Medical Care Coordination (MCC) and other social support services. The LA Care and DPH clinical management teams are working together to discuss how to ensure proper coordination between the Ryan White wrap-around services and Medi-Cal covered services.
- Formulary gaps is another issue, e.g., how does the Medi-Cal formulary compare to ADAP and to HWLA? Medi-Cal managed care plans are responsible for most medications, but the State carves out antiretroviral, antipsychotic and one other group of medications. Those are managed by the state Medi-Cal fee-for-service system. The plans and the State are comparing state, ADAP and HWLA formularies. More information will be available by the December meeting.
- The other major piece explored was network analysis, e.g., who was and would be providing services to the PLWH population, and how many of those were contracted through a managed care plan to ensure patients migrating to Medi-Cal have continuity of care? This gaps analysis showed most HWLA clinics that are Ryan White-funded providers were contracted with the Medi-Cal managed care plans, LA Care or HealthNet. Work is continuing with the remaining two clinics to bring them into the network.
- Ms. Brigham said DHS recognizes that continuity of care is critical for a few populations migrating into Medi-Cal, including PLWH, the homeless and those with medical and behavioral problems. Goals are designed to ensure: people can continue to access their current providers; patients know how to continue to access those providers; and providers know how to assure they will be paid for the services they provide. Often those connections are the main problems.
- DHS also wants underscore to the State that managed care provides the state with a mechanism to monitor the quality of care, as well as providing more cost effective care. Fee-for-service is not as effective at monitoring quality, e.g., whether medications, primary care, and referrals to specialty care are provided in a timely manner. The state will be purchasing care based on quality verified by metrics that document how care is provided.
- Reports on the patient population are public and posted on the Medi-Cal managed care website. Ms. Brigham felt the Commission has a key role in monitoring those reports to hold both providers and health plans accountable. All providers should have the capacity to serve PLWH, not just those with unique funding. There is interest at the federal level in re-arranging and re-allocating funding consistent with expanded health insurance, so advocating for quality is valuable.
- DHS is preparing for managed care first by seeking to be the provider of choice so patients will choose DHS based on criteria important to them, such as access, quality, location and type of providers. The first strategy is to retain current patients.
- Most people think of quality as how polite interactions are, and how quickly phones are answered and appointments made. DHS is working to improve its response in those areas. A new telephone system replaced inactive numbers and tracks how long it takes to answer a call. A new system to determine if a patient needs a specialty appointment has significantly reduced wait times.
- A business unit is being developed so DHS can contract with LA Care and other plans to continue to serve patients. The unit is part of the Managed Care Services Division, a management services organization for DPH, charged with preparations for work in a managed care environment. Hospitals and Ambulatory care sites must be prepared to work in that environment.
- Mr. Fox asked Ms. Calleros if there would also be a gaps analysis of the Covered California and ADAP formularies. Regarding HIV- patients, he asked about access to routine HIV testing, as well as PEP and PrEP. Testing is covered under ACA and most recent CDC guidance is for an annual test for those who are sexually active and more frequent testing for those at higher risk. He recommended health plans play an active role in expanding testing.
- Mr. Ballesteros said Medi-Cal reimbursed for HIV blood tests, but not for the cost of the rapid testing device. That is an issue because most testing is moving toward rapid testing. Regarding LGBT, he noted many national models in Eligible Metropolitan Areas with large at-risk populations, especially LGBT and non-identified LGBT, are reviewing data systems internally and collecting data to identify and report on some health care indicators specific to LGBT populations. He asked if DHS or LA Care planned to collect such data, so outcomes can be compared to the general population.
- Ms. Calleros replied providers must report data on medical services provided. LA Care is presently developing a more robust data analytic tool to improve population management and identify populations that need additional interventions.

Commission on HIV Meeting Minutes

November 14, 2013

Page 5 of 10

- Mr. Munoz reported talking with a number of people who are now in Medi-Cal, but want to transfer to other care. Ms. Brigham replied Medi-Cal is voluntary, but someone eligible for Medi-Cal is not eligible for other government-subsidized health care, e.g., they could seek care through DHS, but DHS would begin a Medi-Cal application at the same time.
- Ms. Calleros added that as the State moved seniors and people with disabilities (SPDs) to managed care, it retained a process for individuals to appeal to stay on Medi-Cal Fee-For-Service. Any accommodations of that kind would be up to the State.
- Mr. Land asked about definitions of specialty care and acuity levels for various co-morbidities. Provider staff has related problems with accessing timely specialty care after a referral was made. Ms. Brigham said the eConsult system creates a dialogue between the primary and specialty care provider. Once the specialist judges a specialty appointment is warranted, Managed Care Services schedules it within two or three days and calls the patient to ensure arrangements are made.
- Ms. Calleros added the primary care provider is responsible to ensure appropriate referrals. Acute, complex, chronic conditions may require a period of regular care from a specialist. In those cases, the primary care provider should review the request for a standing referral for a period of time and authorize it as appropriate.
- The County delivery system uses eConsult. Providers contracted with medical groups have a phone number for a medical management department at the medical group level to coordinate needed services. Ms. Brigham added the State required plans to improve case management coordination during the SPD transition. Chronic case management care coordinators and case managers are all nurses and have access to clinical data to inform decisions.
- Mr. Liso felt the key is retention. He has had cancer for 27 years and is no longer willing to wait for a standard referral. He tells providers a review of his profile should be sufficient for an immediate referral. He has also fought to stay on ADAP because he needs uninterrupted medications without concern about gaps and delays. Continual calls for care are tiring.
- Ms. Tula noted the Hepatitis C treatment environment is rapidly evolving. She urged formulary gaps analysis and review of recent CDC and other guidelines on regular screening for those aged 13-65, and those at higher risk including PLWH.
- Ms. Samone-Loreca asked about dental care. Most agencies only fund up to approximately \$850. Ms. Brigham noted the State limited adult Denti-Cal to emergency services in 2009. On 1/1/2014, the HWLA population will migrate into Medi-Cal and be eligible for Denti-Cal, which will restore some services in May, e.g., prosthetics. Demand is likely to be high as many people lack dental coverage. In addition, there are three dental plans in the County: HealthNet, Access and Liberty.
- Dr. Younai asked about performance measures. Ms. Brigham noted DHS uses a variety of measures including basics, such as mammograms, and measures, such as wait times and staff interactions. A quality Committee meets quarterly to evaluate trends and address issues that may arise at clinics. People may choose their Medi-Cal managed care provider or they will be defaulted to the highest scoring plan. There is, however, no consistent approach as yet to identify PLWH, e.g., viral loads are used as are system codes. A consistent measure would facilitate appropriate placements.
- Ms. Ortega raised concerns about long delays for services needed by the transgender population, e.g., she waited two years for an endocrinology appointment and had to obtain black market hormones. She was also concerned about services for the undocumented. Ms. Brigham noted the County does not ask immigration status, though other counties may, and the federal government does. Medi-Cal managed care health plans are required to provide sex reassignment services. There should be no unreasonable delay. Ms. Calleros added plans are regulated under the State's Department of Managed Health Care, per the Knox-Keene Act, which includes a grievance/appeals process. Access to specialty care in, she believed, must occur within 30 days.
- Regarding those with disabilities, Ms. Calleros said contracts with the State Medi-Cal program require compliance with the Americans with Disabilities Act, provision of durable medical equipment and accessibility surveys of provider sites.
- Mr. Johnson noted health care reform and Medicaid expansion are built on the backbone of the Federally Qualified Health Centers (FQHCs) and Community Health Centers, but many lack staff, resources or infrastructure to meet access and availability standards, while continuing to meet the needs of the undocumented and other uninsured populations. What help is available for them?
- Ms. Calleros replied there have been public policy discussions with the State and community clinic associations to preserve the wrap-around payments to FQHCs for indigent population care. LA Care is holding joint planning meetings with the Community Clinic Association to identify key strategic priorities, technical assistance needs, and other needed support. Based on those discussions, LA Care will help provide managed care training for clinic staff.
- Ms. Calleros will ask about gaps analysis regarding the Covered California and ADAP formularies. LA Care participates in Covered California so it is an appropriate issue. She will also verify that testing services are covered.
- Ms. Calleros will discuss data sets pertinent to LGBT with Mr. Ballesteros.
- Mr. Brigham will ascertain if DHS asks for sexual orientation information when registering for a first visit or appointment.

- ➡ Ms. Brigham said the County is reviewing how to improve care coordination/case management infrastructure and will work with the plans. Ms Calleros added LA Care will also review how to prepare to manage the chronic needs of this population.

9. NEW DIRECTIONS: As the Affordable Care Act (ACA) is Implemented, Local Community Health Planning Organizations Must Define New Missions in Broader Health Care Delivery Systems:

- Dr. Mark, Director, State Office of AIDS (OA), felt it was exciting to work in public health at this time. In 2009, there were about 59 million uninsured Americans or one-sixth of the total population. Approximately 65% of personal bankruptcies are due to health care expenses. Private health insurance accounts for about half of those with insurance. Only about 17% of PLWH have private health insurance, in part because PLWH tend to be less wealthy than the general population.
- The United States spends almost \$8,000 per person per year on health care. That is twice that of other industrialized nations, but overall health outcomes are worse. Outcomes are better for PLWH probably because of the Ryan White Program.
- Federal budget allocations are: 21%, Medicare/Medicaid; 3%, public health; 19%, Social Security; 20%, defense; 6%, interest on debt. That leaves 34% for all other expenses such as education and social programs.
- Most countries have universal government-run health care. That is the Medicare approach. ACA offers expanded Medicaid for those with incomes up to 138% Federal Poverty Level (FPL), and the insurance exchanges are available to those earning more. Participation is not mandatory, but those opting out will pay a fine to ensure a broad enough pool to support the system with both high and low utilizers. The emphasis on marketing Covered California is to ensure sufficient low utilizers to support the system.
- California is already on its way to health care reform primarily due to its early Medicaid expansion, Low Income Health Programs (LIHPs), HWLA in the County. FPL limits varied by county from 25%-200%. LIHPs prompted notable migration from ADAP with 9,000 migrating statewide. Others will migrate due to the Medi-Cal expansion, but fewer are likely to do so in the County since it covered up to 133% FPL under its LIHP. People in counties that covered up to 200% FPL will now migrate to Covered California. That will entail higher out-of-pocket costs for those previously covered by ADAP and Ryan White.
- OA is trying to support PLWH migrating to Covered California with co-enrollment in ADAP. OA-HIPP will pay premiums and ADAP will pay deductibles and co-pays for ADAP formulary medications. There is no current State mechanism to pay for other costs, e.g., physician office visits and laboratory costs. The County and some others are looking into local funding.
- County Ryan White-funded providers are part of the Covered California networks, but that is not true of all providers statewide. OA provided a list of all Ryan White-funded providers to plans to encourage their inclusion in networks for continuity of care purposes.
- OA is working to identify all Covered California health plan formularies so they can be compared to ADAP. Plans are required to provide all medically necessary medications, but it is easier if all antiretrovirals are on the formulary.
- The State is addressing HRSA's payer of last resort requirement by continuing review of ADAP applications/recertifications for Medi-Cal eligibility. A person who can receive Medi-Cal without share of cost is referred. The process is the same, but more people will be eligible in 2014. HRSA requires states to "vigorously pursue" other insurance, but does not prohibit use of Ryan White resources so those eligible for Covered California are informed about their options, but may remain on ADAP if they do not enroll. OA is developing a flow chart for ADAP enrollment workers to help them identify patient options.
- Dr. Mark emphasized that the full ACA transition will take years, e.g., Massachusetts took three to ten years for everyone to transition. It is beneficial for those eligible for Medi-Cal to enroll prior to 3/31/2014 to avoid tax penalties. Due to the LIHPs, many will migrate automatically on 1/1/2014. Covered California will take longer.
- State statute mandates that OA is responsible for coordinating State programs and services related to HIV/AIDS. Due to the ACA, a greater proportion of PLWH over time will receive their medical care through resources other than Ryan White.
- Historically, there has been an emphasis on OA programs, e.g., ADAP, Ryan White Part B and CDC prevention. In the future, fewer people will receive care through those programs and more through other resources, so OA is focussing more on the entire PLWH population and National HIV/AIDS Strategy (NHAS) goals. That requires closer work with the Department of Health Care Services and Covered California and more attention to surveillance data, which reflects the entire population. Program-specific data addresses a smaller population, but remains critical to ensure quality, cost-effective services.
- Ryan White will continue to serve those not covered by ACA, e.g., the undocumented. It is critical to continue to emphasize that all PLWH must receive treatment both for their individual health and for public health, since treatment is prevention.
- It is also critical to articulate the importance of Ryan White support services. Most people understand health care and that antiretrovirals make HIV a chronic, manageable condition, but many do not see the importance of holistic care including, e.g., case management and mental health. Ultimately, the importance of such services must be measurable.

- Another important activity to discuss is HIV testing. ACA will bring health insurance to 80%-90% of Californians. We currently do a large proportion of testing in public health settings. Will that continue or shift to medical settings? Other screenings will also be available with health insurance, e.g., PEP, PrEP, STD, and basic screenings such as blood pressure.
- OA will be working to monitor HIV testing statewide in health care settings not funded by OA to ascertain how much is being done and if it is increasing toward the goal of meeting universal testing guidelines.
- Other areas that should be reviewed are linkage to care, retention in care, adherence support and partner services.
- Mr. Fox noted most are aware the HIV portfolio supported by the General Fund was eliminated in 2009 and that there is now no appreciable funding for ADAP either. Now that the budget has improved, he anticipated significant advocacy for improved funding especially for prevention. Dr. Mark agreed funding was needed to meet NHAS goals. She noted HIV infections nationally are relatively stable while PLWH live longer so the overall HIV+ population is increasing.
- Mr. Johnson asked if OA-HIPP covers COBRA premiums. Dr. Mark said it does if eligibility criteria are met. They are basically the same as for ADA—less than \$50,000 annual income and no other payer source. Premiums are capped by HRSA to ensure the premium is more cost-effective than ADAP, but are generous. All Covered California premiums qualify.
- Ms. Lawson asked about penalties for lack of insurance. Dr. Mark said the first year penalty for an individual is \$95 or 1% of income whichever is greater. The penalty increases each year, which is likely to push more people to enroll going forward.
- Mr. Rivera works as an HIV patient advocate and often helps consumers navigate ADAP, OA-HIPP and the Medicare Part D premium payment program. Communication with the State is a major issue, e.g., with enrollment workers, staff at OA processing applications, and for delayed checks from COBRA administrators, resulting in interrupted coverage. He expressed concern that the system is already overloaded and will be unable to process the increased demands resulting from implementation of the ACA.
- Dr. Mark first urged reporting any loss of coverage due to delays. She noted six to twelve months ago OA developed new OA-HIPP operations guidelines with expectations for staff and clients, e.g., how to process an application and processing timelines, when an enrollment worker would be notified a check would be cut, and when the check would be cut. She wanted to hear feedback to determine if staff is not meeting guidelines or if guidelines are inadequate.
- OA is working with Covered California, specifically with plans, to outline the process and timelines for enrollment workers. One process is batch payments in which the state cuts one check for a plan to cover all those enrolled during a set time period. That should streamline the process by reducing the numbers of checks and working with a limited number of plans.
- Mr. Lopez asked if universal and mandatory testing are the same. Dr. Mark said universal testing is an offer. Studies show those who present late with symptomatic HIV have been HIV+ for years and often had numerous health care interactions, but were not offered a test. Many choose to be tested if it is offered. That allows earlier treatment to improve outcomes.

11. CONTINGUENCY PLANNING: The Commission Facing New Roles in Alternate Scenarios: Status Update on Ballot Initiative to Transfer Public Health Services to the City of Los Angeles:

- Ms. Yoxsimer, Office of the City Administrative Officer (CAO) introduced Ms. Tarpeh, City of Los Angeles. They both worked on a report requested by the City Council on a ballot initiative presented to the City Clerk in March 2013, with signatures submitted in May. The CAO is the budget office and reports to the Mayor and City Council.
- The report was on the cost, timeline and funding associated with the ballot measure, which would require the City to establish its own independent public health department to administer and enforce public health laws in the City.
- Per the measure: “All costs for the establishment of the department are to be derived from current fees collected and paid to Los Angeles County as a result of its activities to enforce public health laws in the City. Future department revenue is to be generated from the collection of all fees including license, permit and/or certification fees generated by the enforcement of the public health code. The department is to be established within 120 days after the ordinance is enacted. The City is to be the only governmental entity able to enforce the public health laws of the City and/or County within the City of Los Angeles.” The initiative explicitly prohibits the City from contracting with the County for enforcement.
- Cost estimates were used as there was no specific information on the magnitude and scope of the proposed department. It was assumed current services would be continued. The City represents about 40% of the County. Based on that, operating expenses were estimated at \$330 million per year. A review of fees and grants to which the City would be entitled yielded income of \$72 million for an annual operating deficit to be covered by the City’s General Fund of \$261 million.
- The deficit would need to be covered by new taxes or cuts to other departments. The proposed department would likely be the third largest department in the City, so covering costs by cutting other departments would be very challenging.
- The estimate does not cover start-up costs, e.g., facilities, laboratories or other items that would need to be bought or built.
- Several other public health departments across the country were reviewed. It is unusual for such departments to cover their costs with fees. The County currently covers about 12% of its costs with fees. The rest is grants and general funds.

- A step-by-step analysis was also made for the timeline, i.e., creating employee classifications, conducting examinations and hiring. The estimate was one to two years. In fact, the City recently consolidated existing classifications that provide public safety services in the General Services Department with the Los Angeles Police Department. Even knowing the positions, what they do and who is in them, it took close to a year. Starting from the ground-up would be a much greater undertaking.
- The City Council received the report in June. It voted to place the measure on the ballot because it must do so or adopt it as an Ordinance. The City Council also directed the City Attorney to take legal action to prevent the measure from being placed on the ballot, in part because placing it on the ballot would cost approximately \$4.5 million.
- Ms. Yoxsimer said her understanding was that complaints were filed and may have been answered. The matter is in court.
- A new ballot measure for a proposed initiative was presented to the City Clerk on 11/8/2013. Ms. Yoxsimer knew little about it, but it has been referred to the City Attorney, who has 10 days to prepare a ballot title and summary. The ballot title and summary is then returned to the City Clerk for final review, after which it can be released for signature gathering.
- Mr. Land asked if estimates included an education piece to help consumers transition. Ms. Yoxsimer replied costs were not estimated separately, but would be included in the assumed 40% if the County has an education piece. The first step if the measure passed would be to determine the department's scope, e.g., whether it would mirror current County services or something else. Mr. Land recommended considering education in advance should a measure go on the ballot and pass.
- Mr. Fox reported the LA Gay and Lesbian Center opposes both initiatives as not in the best interests of the community.
- Mr. Sanjurjo suggested the City produce an annual health report as it did before it ended its own department in the 1960s.

12. SITUATIONAL ADJUSTMENTS: This item was combined with Item 13.

13. FUTURE OUTLOOK: A Commission Agenda for the Future: Determining Commission Goals, Priorities and Expectations After Implementation of the Affordable Care Act (ACA):

- Mr. Johnson introduced Ms. Ransdell, Senior Consultant, The Aspire Group. She facilitated identifying concepts that the Commission feels are most important to address and the work priorities needed to address them.
- Ms. Ransdell suggested opening the discussion on priorities with suggestions from the floor before breaking into groups.
- Mr. Johnson said Dr. Younai requested he relay her priority to identify an approach that will motivate plans and Independent Practice Associations to adopt the HIV standards and best practices developed by the County.
- It was noted that there has been a great deal of discussion about the ACA impact on PLWH. There has been comparatively little discussion on how prevention across the continuum will fit into the discussion, but it is an important area.
- Mr. Land noted there has been no public education campaign about available services for a decade. Stigma continues. Changes pursuant to ACA implementation are enormous and generating fear about making choices and maintaining current providers. He felt it was critical to advertise available services, especially benefit support.
- Mr. Johnson noted Terry Smith was unable to attend today. At the last Executive Committee meeting, he raised the issue of social determinants of health and how to address them, in particular, within standards and best practices.
- The body then broke into groups to further discuss Commission priorities for the next year. Groups reported out as follows:
 - Group 1:
 - Peer education
 - Medical treatment/care
 - Benefits managers/case management
 - HIV service directory – accessibility and updates
 - Research on long-term survivors and perinatally infected populations
 - Legal issues, including the decriminalization of HIV and education on legal rights for all
 - Mental health and substance abuse access
 - Transitional assistance for the post-incarcerated, including mental health, housing and medications
 - Peer support groups
 - Exercise and nutrition services
 - Housing, including improved communication between the Commission and HOPWA
 - Transportation
 - Dental services
 - HIV education for all, which helps the HIV- be responsible for staying HIV-, supports prevention and reduces HIV stigma

- Group 2:
 - Reduce the amount of paper generated by the Commission including review of the option to acquire tablets
 - External branding of the new Commission, what is special about it and how that can be relayed
 - How to developmentally grow as the new body, such as by aligning with NHAS and integrating prevention and care
 - How to work most effectively in the new ACA atmosphere
 - Developing a standards and best practice scorecard that patients can be offered at their physician's office or do online
 - Develop a transitional plan for prevention
 - Educate physicians that everyone who is sexually active is at risk for HIV
 - Develop a checklist of coordinated care
 - Prepare for whatever occurs regarding Ryan White reauthorization, including review of the Commission's Principles
 - Advocate for renewed State commitment to fund HIV services, especially for prevention, PrEP and services cut in 2009
 - Reduce disparity between treatment and care and prevention as care
 - Bring prevention more to the forefront
- Group 3:
 - Develop a transgender census since the community disputes the accuracy of current data needed for planning
 - Risk and prevention strategies for transgender men sexually active with non-transgender men
 - Attention to cultural sensitivity to people with disabilities
 - Advocacy for needle exchange
 - Use language not only of care, but of prevention, to ensure all use the same cultural framework—prevention as care and care as prevention
 - Oversight of standards of care, with a focus on consumer input
 - Benefits enrollment providers accountability training, such as for ACA and ADAP
 - Well-balanced information for everyone
 - How to navigate everything as clients and as providers
 - How to help clients retain self-efficacy, so consumers can find the information they need to care for themselves
 - Take a stand on PEP and PrEP, including funding
 - Retention in care
 - Youth voice and experiences
 - Transparency in decision-making
 - Drug treatment, what the Commission needs to do to get the recovery community engaged in treatment, and anti-stigma activities as they relate to drug treatment
 - Those who seroconvert get prevention information/resources they lacked when HIV-, e.g., drug treatment
 - Treatment for high-risk HIV- people, e.g., drug treatment
 - HCV new medications not on ADAP formulary, what ADAP and Medi-Cal cover and strategies for HIV/HCV co-infection
 - Dental services, including drugs for periodontal issues and fluoride prescriptions
 - Mental health
- Group 4:
 - Develop meaningful community mobilization efforts, collaboration, opportunities and task forces to facilitate leadership skills from the community of PLWH
 - Develop new and innovative ways to attract individuals to services, re-energize support groups, and motivate both HIV+ and HIV- people to participate in services and receive information
 - Continued support to behavioral interventions—do not lose focus on prevention for high risk and HIV+ individuals
 - Reflect on past successes with the prior Commission and Prevention Planning Committee, understand where there was optimal participation and use that as a guide for the future
 - Train new Commissioners and make meetings more accessible to lay people
 - Future efforts should be guided by epidemiology
 - Ensure people know how to access health care and health insurance through the ACA and other new health systems
 - Promote positive messages around sex, particularly with HIV+ individuals
 - Address social determinants of health with HIV- individuals, with an eye toward creating a system of holistic prevention
 - Mandate providers offer HIV testing and educate providers on HIV counseling resources
 - Integrate STD screening and prevention into the programmatic concerns of the Commission
 - Investigate the role of media, social media and marketing websites in disease transmission

- Group 5: Stated focus on priorities and expectations after implementation of ACA:
 - Be advocate and watchdog for clients and providers – the voice of the community – as ACA rolls out
 - Evaluate standards of care and best practices and assure their adoption in health plans
 - LGBT data mining/epidemiology for prevention purposes with health plan participation so they are cognizant of their LGBT community clients and offer appropriate interventions
 - Ensure continuity of care with current providers for at least one year and continuity of care issues going forward
- Ms. Ransdell complimented the comprehensive work, but noted the number of items is too extensive for a one-year work plan. She encouraged attendees to identify items noted by multiple groups. Subjects attendees identified were:
 - Standards of care
 - Mental health
 - Prevention
 - Advocacy for clients
 - Research
 - Education
- Mr. Johnson noted there was significant discussion of what services are needed. He suggested comparing recommendations to the current inventory of services balanced with the County's needs assessment to identify what services are unavailable or geographically impacted to better prioritize recommendations.
- ➡ Compare recommendations with existing services and County needs assessment to better identify priorities.
- ➡ Ms. Ransdell will compile a list of recommendations.

14. LAYING THE GROUNDWORK FOR A NEW AGENDA:

A. Commission's FY 2014 Work Priorities:

- Mr. Johnson complimented the effort extended in developing recommendations. This is the most taxing part of community planning, but lays the groundwork for the coming year.
- ➡ All committees and the Consumer Caucus will review recommendations and further refine them from their perspectives. Results will be brought back to the Commission to form the work priorities for FY 2014.

MOTION 2: Adopt the Commission's work priorities for FY 2014, as presented (*Withdrawn*).

15. COMMISSION COMMENT: There were no comments.

16. ANNOUNCEMENTS: There were no announcements.

17. ADJOURNMENT: The meeting adjourned at 3:05 pm.

A. Roll Call (Present): Roll call was not taken.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 2: Adopt the Commission's work priorities for FY 2014, as presented.	<i>Withdrawn</i>	MOTION WITHDRAWN